

2051 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY OR TOWN <u>Rockville Md</u>		LENGTH OF STAY <u>4 Months</u>		CITY OR TOWN <u>STREET MD</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EMMA</u> (Middle) <u>S</u> (Last) <u>AKINS</u>				(Month) <u>56</u> (Day) <u>8</u> (Year) <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>COI</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 1965</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>MARY SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>218-32-9579A</u>		17. INFORMANT & ADDRESS <u>William AKINS</u> <u>BALAIR RD MD</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Acute pulmonary edema, terminating</u>						<u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>decompensated cardio-vascular disease.</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 15</u> , 19 <u>47</u> , to <u>Feb. 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 6</u> , 19 <u>58</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson M.D.</u>				DATE SIGNED <u>Feb. 8, 1958</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Feb 11/58</u>		NAME OF CEMETERY OR CREMATORY <u>Clark's Chapel</u>	
24. REC'D BY REGISTRAR <u>Feb 13 '58</u>				REGISTRAR'S SIGNATURE <u>Alfred Leach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster Belau</u>	
DATE <u>FEB 13 '58</u>				ADDRESS <u>Forest Hill, Md.</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

STATE QUALITY TEAM

1990

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

BUREAU V. 3

8361 54 834

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2052 CERTIFICATE OF DEATH

Reg. Dist. No.

02025

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Black Horse</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Black Horse</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Anderson Bahel</u>				4. DATE OF DEATH Month Day Year <u>Feb 8 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov-1933</u>	9. AGE (In years last birthday) <u>24</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawyer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Not Known</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-09-534</u>		17. INFORMANT Address <u>Levi B Palmer White Hall Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arterio-sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 1</u> , 1958, to <u>Feb 8</u> , 1958, that I last saw the deceased alive on <u>Feb 7</u> , 1958, and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. France</u> M.D.				ADDRESS (Street, city or town, state) <u>Parkton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>				DATE SIGNED <u>2/8/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 10-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tarrettsville</u>		22d. LOCATION (City, town, or county) (State) <u>Tarrettsville, Harford - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Kurtz</u> ADDRESS <u>Donetskville</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the general director, TO FUNERAL DIRECTOR: Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

FEB 13 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02026

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrode Grace</u>	c. LENGTH OF STAY in 1b <u>LIFE</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harrode Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>627 Fountain St.</u>		d. STREET ADDRESS <u>627 Fountain St.</u>	
3. NAME OF DECEASED (Type or print) <u>Howard</u> First <u>Andrew Bauer</u> Middle <u>Andrew</u> Last		4. DATE OF DEATH <u>February 26 1958</u> Month <u>February</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27, 1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>F.H.I. MAINTAINANCE GERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>JOHN W. BAUER</u>	
14. MOTHER'S MAIDEN NAME <u>MARY K. FRENCH</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WORLDWARI</u>	
16. SOCIAL SECURITY NO. <u>215-12-1875</u>		17. INFORMANT <u>REBECCA M. BAUER</u> Address <u>627 FOUNTAIN ST. HARRODE GRACE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G.S.W. Cerebrum</u> <u>976x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>976x</u> DUE TO (c) <u>976x</u> DUE TO cause last, (c) <u>976x</u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>976x</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot Self</u>	
20c. TIME OF INJURY Month, Day, Year <u>2-26 1958</u> Hour <u>10</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Harrode Grace</u> (County) <u>Hartford</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u> DATE SIGNED <u>2-27-58</u>	
EXAMINER'S NAME (Type) <u>Gerald P. Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Md.</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAR 1, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>	22d. LOCATION (City, town, or county) <u>HARRODE GRACE MD.</u> (State) <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>1233 W. 1st St. Md.</u>		24a. REC'D BY REGISTRAR <u>Mar 3 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF
HEALTH EXAMINERS - CERTIFICATE OF DEATH

HEALTH DEPT.
BUREAU OF HEALTH EXAMINERS

BUREAU V. S.

18 3 1958

RECEIVED

2453 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)		c. LENGTH OF STAY IN 1b X Aberdeen (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 R.D. 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roland Middle Milfred Last Bodt		4. DATE OF DEATH Month February Day 24 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Jan. 1888
9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm-Self Emp.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew P. Bodt		14. MOTHER'S MAIDEN NAME Cora L. Greenland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-1548	
17. INFORMANT Anella Bodt, R.D. 2, Aberdeen, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C-V disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Unk 4-5 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March , 19 56 , to Feb 24 , 19 58 , that I last saw the deceased alive on Jan 30 , 19 58 , and that death occurred at 9 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Darlington, Md. DATE SIGNED 2/25/58			
ACTUAL SIGNATURE Dudley Phillips M.D.		DATE SIGNED 2/25/58	
PHYSICIAN'S NAME (Type) Dudley Phillips M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/27/58	22c. NAME OF CEMETERY OR CREMATORY Churchville Presbyterian	22d. LOCATION (City, town, or county) (State) Churchville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Lanning		ADDRESS Aberdeen, Md.	24a. REC'D BY REGISTRAR DATE FEB 27 '58
		24b. REGISTRAR'S SIGNATURE Redmond	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]

BUREAU V. 3

FEB 27 1938

RECEIVED

NEW YORK, N.Y.
[illegible]
[illegible]
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, it must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G227, 4/8/58

CERTIFICATE OF DEATH

Reg. Dist. No.

02028
180

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Koziah Middle Braxton Last Braxton		4. DATE OF DEATH Month Feb. Day 19 Year 19 58	
5. SEX female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1870
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Fountain		14. MOTHER'S MAIDEN NAME Charlotte Osborne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Thomas Braxton, Abingdon, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular disease DUE TO (c) Hypertensive Cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 0. 31 Month 19 Day 19 Year 19 58 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/12 , 19 58 , to 2/19 , 19 58 , that I last saw the deceased alive on 2/19 , 19 58 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE George T. Stansbury		ADDRESS (Street, city or town, state) DATE SIGNED 569 Revolution St., Havre de Grace, Md 2/22/58	
PHYSICIAN'S NAME (Type) George T. Stansbury		569 Revolution St., Havre de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 23, 1958	
22c. NAME OF CEMETERY OR CREMATORY John Wesley		22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McEwen, Jr.		24a. RECEIVED BY REGISTRAR Abingdon, Md.,	
24b. REGISTRAR'S SIGNATURE W. J. Miller		DATE 2/22/58	

STANDARD STATE DEPARTMENT OF HEALTH—CALIFORNIA

BUREAU V. S.
FEB 26 1938

FEB 26 1958

RECEIVED
FEB 26 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02029

2055 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITEFORD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITEFORD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle CARRIE Last BULL		4. DATE OF DEATH Month 2 Day 27 Year 1958	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3-1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ABRAHAM H. HARE		14. MOTHER'S MAIDEN NAME MARY LAWSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-07-1100	
17. INFORMANT Mrs. Walter B. Morris, Whiteford Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gen. Art. Sclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 57 to Feb 27 , 19 58 , that I last saw the deceased alive on Feb 20 , 19 58 , and that death occurred at 4 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph A. Hunt M.D.		ADDRESS (Street, city or town, state) Delta, Pa.	
PHYSICIAN'S NAME (Type) Joseph A. Hunt, MD.		DATE SIGNED 2/28/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-2-58	
22c. NAME OF CEMETERY OR CREMATORY MIDDLETOWN CEM.		22d. LOCATION (City, town, or county) (State) MIDDLETOWN, BALTO. CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. ...		ADDRESS Stewartstown Pa.	
24a. REC'D BY REGISTRAR DATE MAR 3 1958		24b. REGISTRAR'S SIGNATURE ...	

U. S. A. 1914

1914

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2035. CERTIFICATE OF DEATH

Reg. Dist. No.

02030

1. PLACE OF DEATH a. COUNTY <u>Harford County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shore de Grace</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X. Del Cur</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Box 89, Rt. #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Fernandes</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>February</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-1892</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel F. Collins Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Lucinda Hutton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>108-14-9638</u>		17. INFORMANT <u>Daniel R. Collins - nephew</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO <u>Deep Saphenous Phlebotrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prothrombinemia</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5:00 PM</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-22-58</u> , to <u>2-23-58</u> that I last saw the deceased alive on <u>2-22-58</u> at <u>12:00</u> M., and that death occurred at <u>12:00</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter P. Robinson, M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>8 LAW ST. - Harford, Md.</u>		DATE SIGNED <u>2-23-58</u>	
PHYSICIAN'S NAME (Type) <u>Peter P. Robinson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Kalmar, Harford Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Atchey J. Bullock - Shore de Grace, Md.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>FEB 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB

REGISTERED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02031

2436

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>	
c. LENGTH OF STAY IN 1b <u>6 years</u>		d. STREET ADDRESS <u>218 Washington St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sumner & Revolution Sta</u>			
3. NAME OF DECEASED (Type or print) <u>First Alice Elizabeth Diamond</u>		4. DATE OF DEATH <u>February 5 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-4-94</u>
9. AGE (in years last birthday) <u>63</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Hours <input type="checkbox"/> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mathematician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Business Proving Ground</u>	
11. BIRTHPLACE (State or foreign country) <u>Wayne Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adolph Diamond</u>		14. MOTHER'S MAIDEN NAME <u>Hemietta Pottlizer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs Warren Bush</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>stating the underlying cause lost.</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lowell E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Be/4/17</u>	
EXAMINER'S NAME (Type) <u>Gerold E Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>na</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		2-5-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/10/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		22d. LOCATION (City, town, or county) (State) <u>Parkburg W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Conington Rm. Harford Co., Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 13 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>na</u>		DATE <u>Feb 13 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as soon as possible, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained for files. THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Department. If removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2037 CERTIFICATE OF DEATH

Item 1. Fil-3226 3-7-58 et

Reg. Dist. No.

02032

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PHARMACY</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>PEARLINE FATHMAN COHEN FORMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 23 1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>CC</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>1912</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		9. AGE last birthday <u>46</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u>	
13. FATHER'S NAME <u>Wm Cohen</u>				14. MOTHER'S MAIDEN NAME <u>MARY BOND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>DAVID BROWN FAULSTON MD</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CARCINOMATOSIS</u>						<u>6 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA OF BREAST</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JULY 1953</u> to <u>FEB. 23 1958</u> , that I last saw the deceased alive on <u>FEB. 22, 1958</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul S. Stonesifer Jr.</u>				ADDRESS (Street, city, town, state) <u>M.D. 115 Fulford Ave., BELAIR MD.</u>			
DATE <u>2/23/58</u>				DATE SIGNED <u>2/23/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/26/58</u>		NAME OF CEMETERY OR CREMATORY <u>TABERNACLE</u>		LOCATION (City, town, or county) (State) <u>HARTFORD CO MDE BAYSON</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Joseph J. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. ...</u>			
DATE <u>2/23/58</u>				ADDRESS			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02033

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>S. Main</u>	
3 NAME OF DECEASED (Type or print) <u>George Jones Founds</u>		4. DATE OF DEATH <u>February 7</u> 19 <u>55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 3, 1870</u>
9. AGE (in years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day</u>	
11. BIRTHPLACE (State or foreign country) <u>Md Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>George rounds</u>		14. MOTHER'S MAIDEN NAME <u>Annie Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Robert Campbell, Port Deposit, Md. RD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>900.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u> </u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell down stairs</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> a.m. <u>2-7</u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Port Deposit Cecil Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerard C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u> </u> M.D. DATE SIGNED <u>2-8-58</u>	
EXAMINER'S NAME (Type) <u>Gerard C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-10-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>nopewell</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as soon as possible, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral home. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 11 1976
BUREAU V. S.

2030 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 25, md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEM. HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BABY BOY</u> First <u>Goodson</u> Last		4. DATE OF DEATH <u>FEB 13</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-58</u>
9. AGE (In years last birthday) <u>7</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lowell Goodson</u>		14. MOTHER'S MAIDEN NAME <u>Marilyn Louise Matthews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOKIA (CEREBRAL)</u> <u>154.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CONGENITAL HEART DILATATION</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>11 HRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2:3</u> , 19 <u>56</u> , to <u>2:4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2:4</u> , 19 <u>56</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>R. J. K. [Signature]</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. <u>INTERMENT</u> CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2-4-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>	22d. LOCATION (City, town, or county) (State) <u>Haver de Grace md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. [Signature]</u> ADDRESS <u>Administrator</u>		24a. RECD BY REGISTRAR <u>DATE FEB 13 '58</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR TO FUNERAL HOME: This certificate has been signed by the attending physician and completely filled in. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

1958

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02035

2056 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>MARYLAND</u>		COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-BEL AIR</u>		LENGTH OF STAY (In this place) <u>?</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD COUNTY ALMHOUSE</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JAMES K. GRAY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>FEBRUARY 13 19 58</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>11-24-78</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED-CARPENTER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>
13. FATHER'S NAME <u>RICHARD GRAY</u>				14. MOTHER'S MAIDEN NAME <u>ANN PORTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>FROM RECORDS ON ADMISSION</u> <u>CLARK FITZPATRICK, SUPT. ALMHOUSE</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>CHRONIC CARDIO-VASCULAR DISEASE</u>				?			
(C) <u>CHRONIC OSTEO-ARTHRITIS</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>5/1/53</u> , 19 <u>53</u> , to <u>2/13</u> , 19 <u>58</u> that I last saw the deceased alive on <u>FEB. 10</u> , 19 <u>58</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/16/58</u>		NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		LOCATION (City, town, or county) (State) <u>FOREST HILL MARYLAND</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John G. Tarring</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		ADDRESS <u>Aberdeen, Md.</u>	
DATE <u>FEB 18 '58</u>							



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2057 CERTIFICATE OF DEATH

02036

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston - Rural X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				d. STREET ADDRESS Hess Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle HALL Last HALL				4. DATE OF DEATH Month February Day 25 Year 1958			
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 86 yrs	10. IF UNDER 1 YEAR Months Days Hours Min. 	11. IF UNDER 24 HRS Months Days Hours Min. 	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Barriergard Davis				14. MOTHER'S MAIDEN NAME Mary -----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT CHARLES HALL Address Fallston Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Hypertensive Heart Disease 15 years DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 29 1958 to February 25 1958 , that I last saw the deceased alive on February 25 1958 , and that death occurred at 10 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 							
ACTUAL SIGNATURE S. James Thomson M. D.							
PHYSICIAN'S NAME (Type) S. JAMES THOMSON, Jr., M. D., Jarrettsville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 28, 1958		22c. NAME OF CEMETERY OR CREMATORY West Liberty		22d. LOCATION (City, town, or county) (State) Upper Cross Roads, Harford Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Skunk Jarrettsville Md.				24a. REC'D BY REGISTRAR DATE MAR 4 '58		24b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. I.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2058 CERTIFICATE OF DEATH

Reg. Dist. No. 12037

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PYLESVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PYLESVILLE	
c. LENGTH OF STAY IN 1b 76 YRS.		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NEWTON E. Middle HEAPS Last		4. DATE OF DEATH Month FEB. Day 15 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 5, 1882
9. AGE (In years as birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM OWNER		10b. KIND OF BUSINESS OR INDUSTRY DAIRY	
11. BIRTHPLACE (State or foreign country) PYLESVILLE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS W. HEAPS		14. MOTHER'S MAIDEN NAME RACHEL SCARBOROUGH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. DORA W. HEAPS		Address PYLESVILLE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilat. 177.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of jaw and neck- DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from OCT. 1958 to 15 Feb. 1958 , that I last saw the deceased alive on 15 Feb. 1958 , and that death occurred at 5:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Warrettsville, Md. DATE SIGNED 15 Feb 1958			
ACTUAL SIGNATURE Thos. A.E. Moseley Jr. M.D.		PHYSICIAN'S NAME (Type) THOMAS A.E. MOSELEY JR.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-21-58	22c. NAME OF CEMETERY OR CREMATORY HIGHLAND	22d. LOCATION (City, town, or county) (State) STREET, MD.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins ADDRESS Delta, Pa.		24a. REC'D BY REGISTRAR FEB 24 58	24b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02038

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>H.A. Co. A Home</u>		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Jesserson</u> Middle Last		4. DATE OF DEATH <u>February 18</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27 - 1898</u>
9. AGE (in years last birthday) <u>59</u> yrs		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>19-20-65</u>		16. SOCIAL SECURITY NO. <u>19-20-6515</u>	
17. INFORMANT <u>Clark Schipatruck</u> Address <u>Bel Air</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic C.V. disease</u> 7 x 2.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>None</u> (c), stating the underlying cause last. DUE TO (c) <u>None</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, MD	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-18-58</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 19 - 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Home</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air Rural Harford MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Fisher</u> ADDRESS <u>Bel Air MD</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>DeWitt Smith</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and is any other action within 72 hours after death.

BUREAU V. S.

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MAILED

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CERTIFICATE OF DEATH

02039

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford - Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>	
c. LENGTH OF STAY IN 1b <u>15 days</u>		d. STREET ADDRESS <u>Hartford Memorial Hospital</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Coleman Amos Keithley</u>		4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/10/1868</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USH</u>	
13. FATHER'S NAME <u>James Keithley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kullum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lucy C. Keithley</u>		Address <u>Edgewood, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia + Paratuberculosis (prob. spec.)</u> DUE TO <u>Ascending cholangitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic duct stone, cholangitis, cholelithiasis</u> DUE TO (c) <u>Chronic duct stone, cholangitis, cholelithiasis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 5</u> , 19 <u>58</u> , to <u>Feb 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 20</u> , 19 <u>58</u> , and that death occurred at <u>6:25</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. K. Brendle</u> M.D.		ADDRESS (Street, city or town, state) <u>610 S. Union Ave</u> DATE SIGNED <u>2/20/58</u>	
PHYSICIAN'S NAME (Type) <u>Wm. K. Brendle</u> M.D.		Havre de Grace Md. <u>2/20/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/23/58</u>	<u>Calvary Cemetery</u>	<u>Bel Air Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Harring Aberdeen Maryland</u>		24a. REC'D BY REGISTRAR DATE <u> </u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.
FEB 19 1970

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FEB 19 1970

2059

CERTIFICATE OF DEATH

Reg. Dist. No.

02040

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RUTLEDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RUTLEDGE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>RFD #1 HESS RD, FALLSTON</u>				d. STREET ADDRESS <u>RFD #1 HESS RD, FALLSTON</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>LEWIS</u> Middle <u>LEWIS</u> Last				4. DATE OF DEATH <u>FEBRUARY 13</u> 19 <u>58</u> Month Day Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 1, 1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING AND CARPENTRY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NORTH CAROLINA</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JAMES A. LEWIS</u>			
14. MOTHER'S MAIDEN NAME <u>EMMALINE RAY</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>212-32-3834</u>				17. INFORMANT <u>(WIFE) ALMA LEWIS</u> Address <u>(SAME)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE OF <u>MYO CARDIAC CEREBRAL VASCULAR ACCIDENT</u> <u>ILLUX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR</u> (c) <u>DISEASE WITH ARTERIOSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN</u> <u>OVER 3 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>54</u> , to <u>FEB 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>FEB 11</u> , 19 <u>58</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip W. Hedman</u> M.D.				ADDRESS (Street, city or town, state) <u>307 HICKORY, BEL AIR, Md</u>			
PHYSICIAN'S NAME (Type) <u>PHILIP W. HEDMAN, M.D.</u>				DATE SIGNED <u>FEB 13 '58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb 14-58</u>		<u>Bel Air Mem Gardens</u>		<u>Bel Air Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Kutz, Towertown Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Kutz</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the general director, TO FUNERAL HOME: Page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

FEB 1958

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02041

2060 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fallston, Rural</u>		<u>6 months</u>		TOWN <u>Fallston, Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Mountain Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Margaret</u> (Middle) <u>A.</u> (Last) <u>LEWIS</u>				(Month) <u>Feb.</u> (Day) <u>26</u> (Year) <u>1958</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>Widow</u>	<u>Dec. 19, 1880</u>	<u>77</u> yrs.	Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>housewife</u>		<u>Wales</u>		<u>Wales</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JAMES HOWELLS</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>148-05-9723</u>		<u>Mrs. Edith Loignon, Fallston, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>INANITION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 Mos.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA OF CERVIX Uteri</u>						<u>14 Mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>8/16/58</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/8</u> , 19 <u>57</u> , to <u>2/26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/26</u> , 19 <u>58</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Clifford F. Hudson</u>				ADDRESS (Street, city, town, state) <u>FORK, MD.</u>			
DATE SIGNED <u>2/26/58</u>				DATE SIGNED <u>2/26/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>MAR 1, 1958</u>		<u>Berlin Cemetery</u>		<u>Berlin, N. J.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>FEB 2 P '58</u>		<u>Deane</u>		<u>Joseph W. Foster, Bel Air, Md.</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN ON HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

STANLEY V. S.

1938

DE A 15074

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02042

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY in 1b <u>Like</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lee St.</u>		e. STREET ADDRESS <u>Lee St.</u>	
3. NAME OF DECEASED (Type or print) <u>Bessie Matthews</u>		4. DATE OF DEATH <u>February 13 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20 1889</u>
9. AGE (In years) <u>68</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Md</u>	
11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Matthews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-32-2753</u>	
17. INFORMANT <u>Mrs Lila Young</u>		Address <u>4324 Wilbur Ave Baltimore 12 MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u>			
4221 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2-13-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Foster Bel Air Md</u>		24a. REC'D BY REGISTRAR <u>FEB 18 58</u>	
		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as soon as possible. Write the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 18 1953

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2043

CERTIFICATE OF DEATH

02043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 Edmund Street				d. STREET ADDRESS 118 Edmund Street			
3. NAME OF DECEASED (Type or print) First Abbie Middle Mae Last McKelvey				4. DATE OF DEATH Month February Day 22 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 October 1882	9. AGE (In years last birthday) yrs 75	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Rhoades				14. MOTHER'S MAIDEN NAME Margaret Garris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ** **		17. INFORMANT Eunice V. Castelow		Address 118 Edmund St. Aberdeen Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Acidosis x60x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetic Gangrene, Right Foot DUE TO (c) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 4 days 4 months 5 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 23, 1958 , to Feb. 22, 1958 that I last saw the deceased alive on Feb. 22, 1958 , and that death occurred at 11:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Peter P. Rodman M.D.				ADDRESS (Street, city or town, state) 8 Law Street		DATE SIGNED 2-23 58	
NAME (Type) Peter P. Rodman				M.D. Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2/24/58		22c. NAME OF CEMETERY OR CREMATORY Ligonier Valley Cem.		22d. LOCATION (City, town, or county) (State) Ligonier, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE FEB 26 58	
				24b. REGISTRAR'S SIGNATURE W. J. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 1958

RECEIVED

2044

CERTIFICATE OF DEATH

02044

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL AIR		c. LENGTH OF STAY IN 1b LIFE TIME	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WEBSTER ST		d. STREET ADDRESS WEBSTER ST.	
3. NAME OF DECEASED (Type or print) First Middle Last RUSSELL FLOYD NOONAN		4. DATE OF DEATH Month Day Year FEBRUARY 7 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1903
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Floyd Noonan	
14. MOTHER'S MAIDEN NAME Mollie Scarborough		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 215-03-2982		17. INFORMANT Address ANNE F. NOONAN BEL AIR, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSIS DUE TO (c) CARDIAC INSUFFICIENCY			INTERVAL BETWEEN ONSET AND DEATH 15 MIN 1 MOS 2 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from FEB 19 , 19 54 , to FEB 7 , 19 58 , that I last saw the deceased alive on FEB 7 , 19 58 , and that death occurred at 8:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip W. Heuman M.D.		ADDRESS (Street, city or town, state) 307 HICKORY DATE SIGNED FEB 7, 1958	
PHYSICIAN'S NAME (Type) PHILIP W. HEUMAN		BEL AIR, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 10, 1958	22c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran	22d. LOCATION (City, town, or county) (State) Aberdeen, Harford, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. W. Jones Jr		ADDRESS Abingdon, Md.	24a. REC'D BY REGISTRAR FEB 13 '58 24b. REGISTRAR'S SIGNATURE Clifford Jones

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be filed with the general director, the hospital or attending physician, and completely filled in by the attending physician and completely filled in by the attending physician and completely filled in by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A. 1953

853



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2061

CERTIFICATE OF DEATH

Reg. Dist. No.

112045

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #1				d. STREET ADDRESS Route #1			
3. NAME OF DECEASED (Type or print) First Carroll Middle Stewart Last Osborn				4. DATE OF DEATH Month February Day 18 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 March 1887	9. AGE (In years last birthday) 70 yrs	IF UNDER 1 YEAR Months 18 Days 19 Hours 58 Min	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Luther Stewart Osborn				14. MOTHER'S MAIDEN NAME Sarah Rebecca Wells			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 215-32-7548		17. INFORMANT Address R.D. 1 Mrs. Margaret Osborn Aberdeen, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ABDOMINAL CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA (POLYP) OF COLON DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 weeks 9 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 p. m.	Month, Day, Year 19 58	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 12-7 , 19 57 , to 2-18 , 19 58 , that I lost saw the deceased olive on 2-18 , 19 58 , and that death occurred at 3:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE B. J. Plunkett Jr. M.D.				ADDRESS (Street, city or town, state) 617 W. Bel Air Ave.			
PHYSICIAN'S NAME (Type) Barry J. Plunkett Jr. M.D.				Aberdeen, Md.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/22/58	22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John H. Faring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE FEB 24 1958	24b. REGISTRAR'S SIGNATURE Alb. L. L. L.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 04 1959
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2045

CERTIFICATE OF DEATH

02046

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY <u>Harford</u> <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Harford Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>318 N. Stokes</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Virginia Preston</u>		4. DATE OF DEATH <u>2/22/58</u> 19 <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/18/1923</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Preston</u>		14. MOTHER'S MAIDEN NAME <u>Rida Poplar</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Rida P. Preston</u>		Address <u>318 N. Stokes St. Harford, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA -</u> <u>54X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDITIS -</u> (c) <u>TOXIC ECITRE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 HR.</u> <u>10 YRS</u> <u>BIRTH</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE, 1957</u> , to <u>FEB. 22, 1958</u> , that I last saw the deceased alive on <u>FEB. 22, 1958</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above			
ACTUAL SIGNATURE <u>J. Randall Ross</u> M.D.		ADDRESS (Street, city or town, state) <u>200 N. Union Ave -</u>	
PHYSICIAN'S NAME (Type) <u>J. RANDALL ROSS</u>		DATE SIGNED <u>Harford, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Conington</u>		24a. REC'D BY REGISTRAR <u>FEB 27 '58</u>	
ADDRESS <u>Harford, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1958

DEAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2046

Reg. Dist. No.

02047

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution on Residence before admission) a. STATE <u>md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stimney Road</u>		d. STREET ADDRESS <u>Stimney Road</u>	
3. NAME OF DECEASED (Type or print) <u>Terresso Pratt Reid</u>	4. DATE OF DEATH <u>February 27 1958</u>		5. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/15/1893</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Amuel Pratt</u>		14. MOTHER'S MAIDEN NAME <u>Ida Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Catherine E Butler - Aberdeen, md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CVD disease</u>			
422.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M D		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>B. A. Air</u> M D	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M D</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/2/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ab. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		24a. REC'D BY REGISTRAR <u>Ab. Cemetery</u>	
24b. REGISTRAR'S SIGNATURE <u>Ab. Cemetery</u>		DATE <u>MAR 6 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as soon as possible, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 6 1909

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2062

CERTIFICATE OF DEATH

02048

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Aberdeen (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1				d. STREET ADDRESS R.D. #1			
3. NAME OF DECEASED (Type or print) William Morgan Reid				4. DATE OF DEATH Month February Day 23 Year 1958			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Dec. 1893		9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 04 Days 19 Hours 58 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman, Salvage Sect U.S. Govt.				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME George Reid			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 217-01-3951				17. INFORMANT Teressa Reid Address R.D. #1, Aberdeen, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Acute Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Pulmonary Edema DUE TO 2 days (c) Arterio-sclerotic Heart Disease DUE TO 2 days							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 6/6 , 19 53 , to 2/23 , 19 58 , that I last saw the deceased alive on 2/23 , 19 58 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE George T. Hamburg				ADDRESS (Street, city or town, state) M.D. 5448, Baltimore St., Harford County, Md.			
DATE SIGNED 2/24/58				PHYSICIAN'S NAME (Type) George T. Hamburg			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/58		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Tanning				ADDRESS Aberdeen, Md.		24a. RECEIVED BY REGISTRAR FEB 27 1958	
24b. REGISTRAR'S SIGNATURE W. B. ...				24c. REGISTRAR'S SIGNATURE W. B. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB

RECEIVED

2047

CERTIFICATE OF DEATH

Reg. Dist. No. 2049

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE				c. LENGTH OF STAY IN 1b 50 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Franklin St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GUSTAVOUS M. SINCLAIR				4. DATE OF DEATH Month Day Year FEB. 18 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 9 1874	9. AGE (In years last birthday) yrs. 83	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY BOATS (WATER)		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SINCLAIR				14. MOTHER'S MAIDEN NAME Louise MASON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Theresa Williams		Address BOURBON, ST HAVRE DE GRACE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-4 , 19 57 , to FEB. 12 , 19 58 , that I last saw the deceased alive on 1-6 , 19 58 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Günther D. Hirsch M.D.				ADDRESS (Street, city or town, state) 421 Congress Ave. Havre de Grace Md.			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB 21 1958		22c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.		22d. LOCATION (City, town, or county) (State) HAVRE DE GRACE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR FEB 24 58	
				24b. REGISTRAR'S SIGNATURE G. D. Hirsch			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

173 01 1958

RECEIVED

2063 **CERTIFICATE OF DEATH**

02050

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		LENGTH OF STAY (in this place) <u>5 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Rt. # 7</u>			
3. NAME OF DECEASED (Type or Print) <u>Frances</u> (First) <u>Szukielevitz</u> (Middle) <u>Szukielevitz</u>				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>3</u> (Year) <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 7, 1893</u>		9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unkown</u>				14. MOTHER'S MAIDEN NAME <u>Unkown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Joseph J. Szukielevitz, Bradshaw, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Carcinoma of uterus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr. 1, 1956</u> to <u>Feb. 3, 1958</u> , that I last saw the deceased alive on <u>Feb. 1, 1958</u> , and that death occurred at <u>9:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William A. Tyson</u>		DATE THEREOF <u>Feb. 5, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		DATE SIGNED <u>Feb. 3, 1958</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Arthur</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McGowan Jr.</u>		ADDRESS <u>Baltimore, Maryland. (22)</u> <u>Abingdon, Md.</u>	
DATE <u>FEB 6 '58</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 155C 1-55 10M

BUREAU V. S.

1903

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02051

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. STREET ADDRESS <u>Aberdeen Road</u>	
3. NAME OF DECEASED (Type or print) <u>Virginia Gullion Tibbs</u>		4. DATE OF DEATH <u>February 4</u> 19 <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/1891</u>
9. AGE (in years last birthday) <u>66</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jack Gullion</u>		14. MOTHER'S MAIDEN NAME <u>Lee Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213/16/4924</u>	
17. INFORMANT <u>Brother Johnson Box 351 Aberdeen #2 Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>26</u> DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> <u>Amputation of right (diabetic gangrene)</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Darrington Aberdeen Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 10 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Feb 10 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as soon as possible, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Medical Examiner's Office along with form F-10. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

3

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02052

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Hampden</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampden</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hampden Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Mill St Port Deposit</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bertha M. Webster</u> 5. SEX <u>F</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>February 29 1958</u> 8. DATE OF BIRTH <u>April 25, 1928</u> 9. AGE (in years last birthday) <u>29</u> yrs. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private home</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Smith</u>		14. MOTHER'S MAIDEN NAME <u>Estella Cain</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>214-34-3460</u> 17. INFORMANT <u>Joseph Webster, Port Deposit, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>3rd degree burns body</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) <u>Due to</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Buttled Gas Exploded</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>1-31 1958</u> Hour <u>3</u> p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> 20f. (City or town) <u>Port Deposit Cecil Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u> DATE SIGNED <u>2-2-58</u>	
EXAMINER'S NAME (Type) <u>Gerald P Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		22b. DATE THEREOF <u>2-5-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mosanna</u>		22d. LOCATION (City, town, or county) <u>Darlington, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>See a Patterson & Son</u> ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 5 1958</u> 24b. REGISTRAR'S SIGNATURE <u>Aw. Beach</u>	

BUREAU V. S.

189

RECEIVED

2050

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>	
c. LENGTH OF STAY IN 1b <i>About 70 yrs</i>		d. STREET ADDRESS <i>315 So. Stokes Street</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>315 So. Stokes Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>RUFUS</i> Middle <i>E.</i> Last <i>WING</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>4</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 21, 1883</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months <i>4</i> Days <i>14</i>	IF UNDER 24 HRS Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>St. Dept. City</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford County, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Abe Wing</i>		14. MOTHER'S MAIDEN NAME <i>Maria Hallaway</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-12-2463</i>	
17. INFORMANT <i>Mrs. Verlie Wing</i>		Address <i>315 So. Stokes St Harre de Grace, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Acute Coronary Thrombosis</i> DUE TO (b) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <i>Arteriosclerotic Heart disease</i> DUE TO (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>11</i> p. m. <i>15</i> 19 <i>57</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11/15</i> 19 <i>57</i> , to <i>2/4</i> 19 <i>58</i> , that I last saw the deceased alive on <i>2/3</i> 19 <i>58</i> , and that death occurred at <i>11:45 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>George T. Stansbury, M.D. 569 Revolution St., Harre de Grace, Md. 2/6/58</i>			
ACTUAL SIGNATURE <i>George T. Stansbury</i>		PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/7/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St James Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Harre de Grace, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullenk</i>		ADDRESS <i>Harre de Grace</i>	
24a. REC'D BY REGISTRAR <i>FEB 10 58</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. ...</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

WILLIAM BOMID

BUREAU V. S.

FEB 10 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2064

CERTIFICATE OF DEATH

02054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL or give nearest town) CARDIFF				c. LENGTH OF STAY IN 1b 13 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) GEORGE ELLSWORTH YOUNG				4. DATE OF DEATH FEB. 25, 1958			
5. SEX M		6. COLOR OR RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 18, 1890	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) YORK CO., PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARETAKER				10b. KIND OF BUSINESS OR INDUSTRY CEMETERY			
13. FATHER'S NAME ADAM YOUNG				14. MOTHER'S MAIDEN NAME EMMA STEVENSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 166-12-4883			
17. INFORMANT MARY E. YOUNG, CARDIFF, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Hypertensive C-VD Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 yrs (c) Interval between onset and death PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute prostatitis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 2, 1958 to Feb 24, 1958 , that I last saw the deceased alive on Feb 24, 1958 , and that death occurred at 6:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Ralph Henky MD				ADDRESS (Street, city or town, state) Churchville Md			
PHYSICIAN'S NAME (Type) J. Ralph Henky MD				DATE SIGNED Feb 26			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 2-28-58		22c. NAME OF CEMETERY OR CREMATORY HENDERSON HILL	
22d. LOCATION (City, town, or county) (State) BELAIR, MD.							
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins, Delta, Pa.				24a. REC'D BY REGISTRAR FEB 27 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 27 1958

RECEIVED